KIRKLAND DENTISTRY
FAMILY & COSMETIC
DAVID RICHARDSON DDS

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I authorize the release of the following:

☐ Panoramic of Full Mouth X-rays- within past 5 years

☐ Bitewing or Periapical X-rays- within past 12 months

☐ Other X-rays

Specify which: _____

☐ Dental Records

☐ Medical Records pertinent to upcoming dental appointment

Release this information from:

Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Send this information to:

Name: Kirkland Dentistry

Address: 11830 NE 128th St, Ste 201, Kirkland, WA 98034

Phone Number: 425-823-6820 Fax: 425-820-2427

Email: info@KirklandDentistry.net

Patient Signature:_____Date:_____